MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Mandated report on specialty hospital (Legal overview, description of specialty hospitals, site visits, markets, payer mix)
-- Ariel Winter, Carol Carter, Jeff Stensland

MR. HACKBARTH: Good morning. First on our agenda this morning is the mandated report on the specialty hospitals.

MR. WINTER: Good morning.

The Medicare Modernization Act requires us to study the issue of physician-owned specialty hospitals. The report is due in March of next year.

Specifically, we're required to compare costs of care of physician-owned specialty hospitals to community full service hospitals, compare the extent to which type of hospital treats patients in specific DRGs, compare the mix of payers for each type of hospital, analyze the financial impact of specialty hospitals on community hospitals, and finally examine whether the inpatient prospective payment system should be revised to better reflect the cost of care. Today's presentation will include four topics. I will provide an overview of the federal laws governing physician investment in the hospitals and other facilities and also discuss strategies used to align physician and hospital financial incentives. Carol will then describe the characteristics of physician-owned specialty hospitals and the markets in which they are located. Jeff will present preliminary data from our analysis of payer mix. And finally, Carol will discuss the findings from our site visits to three markets with specialty hospitals.

Our discussion of the legal restrictions on physician investment in health care facilities is based on research conducted by Kevin McAnaney for MedPAC and I want to thank him for his excellent work.

This topic is important because the context for our report is the Medicare Modernization Act's moratorium on physician investment in new specialty hospitals.

In addition, these laws relate to other services the Commission has examined, such as outpatient imaging.

First, we'll look at the arguments put forth by critics and supporters of physician ownership of health care providers. We will then discuss the major federal laws in this area, the anti-kickback statute and the Stark law. Finally, we'll review strategies used by hospitals to align their financial incentives with those of physicians and how these approaches are constrained by federal laws. Some of these approaches are relevant to the specialty hospital issue.

Supporters of physician ownership contend that physicians are a valuable source of capital for health care facilities. They also argue that physician investments can improve quality, efficiency and access to care. For example, physicians with a financial stake in an ambulatory surgical center or hospital may have a greater incentive to streamline operations.

On the other side, there are generally three rationales for restricting physician investment in facilities to which they refer patients. First, several studies by GAO, the OIG and other researchers have found that physicians with a financial interest in ancillary equipment and facilities have higher referral rates for those services than other physicians.

Second, there is a concern that physician ownership could improperly influence professional judgment. Ownership creates a financial incentive to refer patients to the facility owned by the physician which may or may not be best for the patient. There could also be incentives to refer patients for too many services and to economize on care in ways that reduce quality.

The third concern is that physician investment could create an unlevel playing field between facilities. Physician-owned providers could have a competitive advantage over other facilities because physicians influence where patients receive care.

The anti-kickback statute was enacted in 1972 and has been amended several times since. It prohibits offering or receiving anything of value to induce the referral of patients for services covered by federal health programs. Violators can be subject to criminal penalties, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

The statute applies to all types of services and entities but it requires proof that there was knowing and willful intent to violate the law. It is enforced on a case-by-case basis, which limits its deterrent effect.

In the late 1980s, the OIG attempted to apply the statute to physician investments and ancillary facilities to which they refer patients. The OIG's position is that some of the companies organizing these joint ventures are, in effect, buying physician referrals by offering the physicians high returns on modest investments with little financial risk.

However, the OIG has been largely unsuccessful at using the statute to restrict physician joint ventures. Such cases are resource intensive, time consuming and face a high burden of proof.

These limitations led to the Stark law, which is focused exclusively on financial arrangements between physicians and facilities to which they refer patients. The Stark law prohibits physicians from referring Medicare and Medicaid patients for certain services to a provider with which the physician has a financial relationship. Violators can be subject to denial of claims, civil monetary penalties and exclusion from the Medicare and Medicaid programs, but not criminal penalties.

The Stark law goes beyond the anti-kickback statute by prohibiting many types of financial arrangements between physicians and entities to which they refer patients regardless of any intent to influence referrals. Unlike anti-kickback, the Stark law applies to a clearly defined set of services.

The original Stark law applied only to clinical labs but amendments to the Stark law known as Stark II extended this prohibition to several other services, which are all listed on the slide. The Stark laws generally prohibit physician ownership of facilities that provide these services. Compensation

arrangements between physicians and facilities are usually allowed if the physicians are paid fair market value for their services.

The Stark law permits certain financial arrangements based on the belief that they are unlikely to lead to overuse of services. Here are some relevant examples. First, the law allows physicians to own ASCs as long as the ASC does not provide ancillary services. There's a perception that physician investment in ASCs where they perform services involves less risk of overuse because the physician receives a professional fee regardless of where he or she performs the service.

Physician who do procedures in ASCs that they own may also receive profits from the facility fees. However, these profits are probably only a small additional financial incentive.

In addition, the ASC could be viewed as an extension of the physician's office practice and there's a principle that physicians should have autonomy over their work place.

Second, the in-office ancillary exception permits physicians to provide most ancillary services in their own offices. The logic is that there is often a need for quick turnaround time on diagnostic tests, although the exception also applies to other services such as physical therapy.

Third, the law protects physician investment in hospitals as long as the interest is in the whole hospital rather than a hospital subdivision. Because hospitals generally provide a wide range of services, the theory is that referrals by an individual physician would be unlikely to have a significant effect on overall profits.

The growth of physician-owned single specialty hospitals raises important questions. Because specialty hospitals derive their revenue from a limited range of services, is there a greater opportunity for individual physician investors to influence hospital profits which could affect their referrals? Or is physician ownership of a specialty hospital justified because the hospital may function as an extension of the physician's practice?

The MMA prohibited the development of new physician-owned specialty hospitals for a period of 18 months, ending in June 2005.

Finally, the Stark II final rule permits physician ownership of entities that provide equipment and services to facilities covered under Stark as long as the physicians don't own a facility that actually bills Medicare. For example, a physician could own an MRI machine and lease it to an imaging center for a fixed amount per use. Every time the physician refers a patient to the imaging center for an MRI, he or she receives a fee from the imaging center for the use of the equipment. This creates the same financial incentives as direct physician ownership of the imaging center.

So far we have focused on the physician perspective. Now we're going to look at strategies used by hospitals to align their financial incentives with those of physicians and the legal constraints on those activities.

One approach we've already talked about is offering physicians an ownership stake in the hospital. Aside from

specialty hospitals, there's broad protection under the Stark law for this type of arrangement. Other strategies include medical practice support, acquisition of physician practices, partnering with physicians and economic credentialing.

Medical practice support can include help with recruiting physicians, subsidized office space and low interest loans. These activities carry legal risk under Stark and anti-kickback if the support is provided for less than fair market value.

Another approach is to buy physician practices which provides the hospital with a source of patients. In theory, this vertical integration would also increase the hospital's bargaining power with health plans. The Stark law allows hospitals to control referrals made by employee physicians subject to the patient's own choice and insurance coverage and the physician's professional judgment.

This strategy carries legal risk if the hospital overcompensates employee physicians and there have been several expensive legal settlements in such cases. Many hospitals have found this model unprofitable and have divested their physician practices.

Another strategy is for hospitals to partner with physicians by co-investing in joint ventures such as ASCs and imaging centers or by creating gainsharing arrangements. In gainsharing, the hospital shares cost savings with physicians who cooperate in efforts to reduce costs. For example, the physicians may agree to use less expensive equipment and supplies.

However, the OIG has ruled that gainsharing violates a legal provision prohibiting hospitals from paying physicians to reduce services to Medicare patients. This provision was meant to prevent hospitals from providing financial incentives to physicians to discharge patients quicker and sicker under the inpatient prospective payment system. The OIG said that gainsharing has the potential to improve care and reduce costs but that they need statutory authority to regulate these arrangements.

Because of the potential to better align hospital and physician financial incentives, gainsharing may be a productive area for us to do further research.

Finally, economic credentialing is an approach in which hospitals restrict staff privileges for physicians who invest in or are employees of competitor facilities. This can take two forms. In some cases, the hospital prohibits its medical staff from having financial relationships with competitors. In others, the hospital requires its staff to admit a certain percent of their patients to the hospital. This strategy has recently attracted fierce opposition from physicians and has been challenged in several state courts.

Now we'll move on to Carol's presentation.

MS. CARTER: To conduct our study of specialty hospitals, we first had to define them. To meet our mandate, our first criteria is that the hospital has to be physician-owned. The law also specifically discussed hospitals primarily engaged in heart, orthopedic and surgical cases.

We developed a criterion of concentration based on Medicare data, since it is the only nationally available dataset. We

defined a specialty hospital has having 45 percent of its Medicare discharges in the heart or orthopedic MDC or were surgical cases. Or a hospital could have 66 percent of its cases in two of these categories. This is very consistent with the definition that GAO used on two of its studies last year. They used 66 percent of its cases in two MDCs.

To include the hospitals in our study and to make sure that each hospital had enough cases to analyze, we included every hospital that had at least 25 Medicare discharges in 2002. This is also consistent with what GAO did. where they included 20 cases for every hospital. The GAO study also included hospitals that were not physician-owned and also included women's hospitals.

Using these criteria, we found 48 hospitals that met our criteria: 12 of them were heart, 25 were orthopedic and 11 were surgical. We know that there's been rapid growth in specialty hospitals and there are an equal number of hospitals that have formed a since 2002. But because we didn't have data on them, we could not study them.

Our mandate also required that we compare specialty hospitals to community hospitals. Our first comparison group was any community hospital in the same market. Here we used the Dartmouth Hospital referral regions as our definition of hospitals.

We also developed two other comparison groups. First, we looked at hospitals that were identical to specialty hospitals in terms of concentration but were not physician-owned. We called them peer hospitals. Peer hospitals do not have to be in the same market as specialty hospitals.

A second category included hospitals that were located in the same market as specialty hospitals and provided similar services as specialty hospitals, and we called these competitors.

We first looked at ownership characteristics. All specialty hospitals were for-profit compared with 17 percent of PPS hospitals. Twenty-three percent are partly owned by another hospital. A larger proportion of surgical hospitals were owned by another hospital, compared with heart and orthopedic hospitals.

Forty-three percent of specialty house are part of a chain and this is comparable to the share in all PPS hospitals. A larger proportion of heart hospitals are part of a chain than orthopedic and surgical hospitals.

On average, 60 percent of the hospital is owned by its physicians but this ranged from 18 percent to the entire hospital. Surgical hospitals had the highest share owned by their physicians, averaging 73 percent, compared with heart hospitals where only 35 percent of them were owned by their physicians.

The median share owned by a single physician is 4 percent. There was a large range in the individual shares owned. At a third of the hospitals, the largest share was 2 percent or less. And yet at 20 percent of the hospitals the largest share was 15 percent or more.

More heart hospitals had smaller shares owned by a single

physician.

Looking at location, we found that the specialty hospitals are not evenly distributed across the country. Ninety-four percent are located in states without certificate of need. Specialty hospitals are concentrated in certain states. We found 59 percent were located in just four states: Kansas, Oklahoma, South Dakota and Texas. Some of these state have much larger shares of specialty hospitals than they do of PPS hospitals. For example, South Dakota has less than 1 percent of PPS hospitals but has 16 percent of specialty hospitals. Kansas has 2 percent of PPS hospitals but 12 percent of specialty hospitals.

We've noted that newly formed specialty hospitals that are not part of this analysis also tend to be located in the same states and often in the same markets.

Licensure laws may facilitate where hospitals locate. Some states, such as Kansas and South Dakota, have two categories of hospital licenses. There specialty hospitals do not have to offer a full array of services to be licensed as a hospital. Other states preclude their development, such as Florida. And not all states require emergency rooms or emergency departments.

When we looked at the characteristics of the hospital locations, we found that specialty hospitals tended to be located in mid-sized MSAs that have larger population growth, a lower proportion of elderly, lower managed care penetration, and similar poverty and per capital incomes.

Their MSAs also tend to have fewer beds and fewer surgical specialists per capita. And there was a little bit of variation by the type of specialty hospital market. Heart hospital MSAs tend to locate in high managed care penetration areas and do not have low surgical specialists per capita.

The beneficiaries in MSAs with and without specialty hospitals had comparable health status and service use.

Turning to hospital characteristics, the first thing to note is that specialty hospitals are small. The average heart hospital has 52 beds. The average orthopedic and surgical hospital has about 15.

Two-thirds of Medicare cases are treated in specialty hospitals that are heart hospitals. Once specialty hospital is a teaching hospital and about six receive disproportionate share payments.

About half the specialty hospitals have an emergency department but there is considerable variation across the different types of specialty hospitals. Two-thirds of heart hospitals have an emergency department but only one of the surgical hospitals did.

Regarding their staffing, all of the heart hospitals staff their emergency departments with physicians night and day, compared with only one orthopedic hospital and no surgical hospital. At these other specialty hospitals, they use a mix of physicians in the hospital and on call.

When we looked at the mix of patients treated at specialty hospitals, we see quite a bit of concentration. Heart hospitals are more focused on heart care and within heart care the specialty hospitals were more focused on surgeries and procedures.

At heart hospitals, 66 percent of their heart cases are surgical compared with 40 percent at their competitors and 29 percent at community hospitals. Thirty-three percent of specialty hospitals are medical cases compared with 71 percent at community hospitals. Over one-third of the cases at heart hospitals are coronary artery bypass grafts and angioplasties compared with 19 percent at competitors and 14 percent at community hospitals.

Looking at specialty hospital market shares, we found that specialty hospitals account for a much larger share of the surgeries and procedures done in their markets than their overall market share. For example, heart hospitals treated 4.5 percent of the cases in their markets but performed over a quarter of the local angioplasties and CABGs.

Given their smaller size, orthopedic and surgical hospitals play a smaller role in their markets. But even here, they treat a much larger share of the orthopedic cases in their markets compared to their overall market share. For example, they treated 1 percent of their market cases but almost 5 percent of the orthopedic surgery cases.

DR. REISCHAUER: Excuse me, Carol. Are these Medicare-only numbers?

MS. CARTER: Yes, they are.

Now, Jeff's going to talk about payer mix.

DR. STENSLAND: The Medicare Modernization Act requires that MedPAC compare the payer mix of physician-owned specialty hospitals to full-service community hospitals. We also compare physician-owned specialty hospitals to the set of peer hospitals that Carol described earlier.

First, we'll look at why would payer mix differ and then we'll take a look at the data.

The payer mix of physician-owned specialty hospitals may differ from the community hospitals for several reasons. First, starting at the upper left-hand corner of this slide, we have patient selection. Community hospitals frequently assert that physicians have a financial incentive to send profitable patients to their hospital and unprofitable patients to the community hospital.

Second, we have types of services offered. For example, if the specialty hospital does not offer obstetric services, it may have a lower than average share of Medicaid patients.

Third, emergency room services. If a hospital does not have a staffed ER, it may receive fewer indigent patients.

Fourth, there's simply the geographic location of the hospital.

And fifth, community hospitals may try to freeze out physician-owned hospitals from private payer contracts. If a community hospital is successful in obtaining an exclusive preferred provider contract with a large insurer, the specialty hospital may have difficulty attracting patients with that type of private insurance.

Now let's take a look at the data. First, we examine cost report data on hospital discharges. The table shows that physician-owned heart and orthopedic hospitals tend to have lower Medicaid shares than community hospitals in the same markets.

Heart hospitals tend to have a high share of Medicare patients while orthopedic hospitals tend to have an average share of Medicare patients.

There are couple of limitations in the cost report data. First, Medicare cost reports don't have data on self-pay patients. They are lumped together with privately insured patients in that all other category of patients you see on the right-hand side of the slide.

Second, the differences we see in Medicaid shares may be just due the types of services provided by the hospital. To address these limitations, we conducted a survey of 134 hospitals that met our criteria for being either a physician-owned specialty hospital or a peer hospital. Using survey data, we compare physician-owned specialty hospitals to peer hospitals that focus on a similar set of services.

This slide differs from the prior table in several ways. First, we're using survey data. The hospitals are self-reporting their fields of clinical specialization and self-reporting their payer mix. Second, we are measuring payer mix by examining net patient revenue rather than discharges. Third, we're focusing just on heart hospitals on this slide.

We find that physician-owned heart hospitals tend to have lower Medicaid shares than peer heart hospitals. This holds true for physician-owned hospitals with an ER and those without an ER. We do not see big differences in the revenue from self-pay patients.

Of course, hospitals may have a small share of net patient revenue from self-pay patients either due to treating few self-pay patients or due to collecting little from the self-pay patients they treat.

Now, we'll turn to the orthopedic and surgical hospitals.

From this table, we see that physician-owned orthopedic and surgical hospitals tend to have lower levels of Medicaid revenue than their peers who describe themselves as orthopedic or surgical hospitals. However, we should caution that there's a high level of variance in the Medicaid shares for peer, orthopedic and surgical hospitals. A few nonprofit orthopedic and surgical hospitals have very high Medicaid shares but many peer hospitals have Medicaid shares of 3 percent or less. The 9 percent Medicaid share shown on the slide for peer hospitals is the mean value for this highly variable group.

Orthopedic and surgical hospitals tend to receive a majority of their revenue from patients with private insurance. Physician-owned peer hospitals often have similar levels of net revenue from self-pay patients.

To summarize our payer mix findings, first physician-owned specialty hospitals tend to have lower Medicaid shares than both community hospitals in their market and peer hospitals that provide similar services. However, it should be noted that there's a wide variance in the Medicaid shares among peer, orthopedic and surgical hospitals. Heart hospitals tend to have high Medicare shares. Orthopedic and surgical hospitals tend to have high shares of patients with private insurance.

These findings are consistent with earlier work by the GAO and consistent with what we found on site visits to communities

with physician-owned hospitals.

Carol will now talk about those site visits.

MS. CARTER: As part of our study, we conducted site visits to three markets with specialty hospitals to hear from stakeholders about the issues surrounding specialty hospitals and about the impact specialty hospitals have had on community hospitals. We visited Austin, Wichita and Manhattan, Kansas, and Sioux Falls, South Dakota.

We picked our sites to be geographically diverse, represent a mix of types of specialty hospitals within a single site, and include hospitals that had been around long enough to hear about the impacts on community hospitals.

Each of our sites included a heart hospital because even though they represent only one-quarter of specialty hospitals, they treat two-thirds of the Medicare cases seen at specialty hospitals.

At each site we spoke with a mix of physicians, some practiced at both types of facilities, some only at community hospitals. We talked with hospital CEOs, CFOs, and in markets where the specialty hospitals had emergency rooms, the city's director of emergency medical services.

The hospitals were generous with their time in preparing materials for us and in making people available to us during our visits.

I'd like to emphasize here that what we're reporting here is what physicians and the hospital personnel told us, much of which we could not verify. There were large discrepancies in what we heard. Some of the issues, such as case selection, will be examined in detail later in other analysis and we'll present it later this fall.

The physicians we spoke with told us they set up specialty hospitals for two reasons: governance and opportunities to increase their income. The most frequently mentioned reason was governance. Physicians wanted to control decisions made about the patient care areas of the hospitals so they could improve their productivity, improve the quality of care provided and make the hospital more convenient to them and their patients.

At hospitals that had started at ASCs, the facilities worked so well they wanted to expand their practices into patient care areas that required overnight stays.

We repeatedly heard about the frustrations physicians had with community hospitals. Many physicians said they tried to work with the community hospitals but that decision making took too long and did not support their practices. Some physicians acknowledged that community hospitals had multiple priorities, which the appreciated but did not want to compete with.

Many community hospital administrators acknowledged they had been slow to react to the issues raised by their physicians. Less frequently we heard about physicians wanting to generate more revenue to counter perceived declines in their incomes.

Specialty hospitals created three kinds of opportunities for physicians. The first is increased throughput. They can treat more cases in a given amount of time. For investors, most older facilities pay out annual dividends, frequently in excess of 20 percent. The third is they can capture the facility portion of

payments.

There was considerable variation in how important governance versus ownership was to physician involvement. Several physician investors we spoke with said that ownership had not been key to their decision and they would have been content to have the community hospitals address their concerns.

The first order of business in developing a specialty hospital is to secure a core set of admitters. Usually, at the hospitals we visited, the key admitters were owners. Physicians typically sought financing for 70 to 80 percent of the cost of the hospitals. Banks often wanted to see evidence of physician commitment in the form of physician investment before loans were made. Rather than find all of the equity themselves, physicians often turned to outside investors. Particularly at the start of facilities, physicians wanted to minimize their risk and outside investors -- often non-physicians, sometimes a national chain and sometimes a local hospital were sought. More often the investors were local business people.

In these cases, physicians made small investments, typically on the order of $25,000 to $50,000. When owners sell their shares, for example when they retire from practice, the shares are generally sold to other physicians. A couple facilities noted they expected their physician investors to bring at least some of their volume to the specialty hospital.

The specialty hospitals we visited usually required their physicians to have privileges at a community hospital. As a result, physicians could admit certain types of cases to one hospital and other cases to another. Physicians practicing at most specialty hospitals accept restrictions on the range of supplies, stents, implant devices, restrictions physicians told us they had resisted when they practiced at the community hospital.

Many of the specialty hospitals we visited did not have emergency rooms, which increases their control over admissions. But even having an emergency room didn't mean the hospital was ready to treat emergencies. At one hospital we visited, it had to turn on the lights of its emergency room to show us the space.

However, at two of the four heart hospitals we visited had emergency rooms and were fully staffed day and night. They accepted cardiac and non-cardiac cases. Another heart hospital we visited is planning to open an emergency room.

Many physicians practicing at orthopedic and surgical specialty hospitals acknowledge that they selected patients who were appropriate for their facility. Some couch selection in terms of specialization and service offerings. The specialty hospital didn't have certain services so the physician couldn't responsibly admit patients who might need them.

Physicians practicing at heart hospitals more frequently disagreed about patient selection. Some said they admitted medically complex cases to community hospitals. Others said they didn't selectively admit cases to one type of hospital or another.

Data from one heart hospital chain indicated that fewer of its patients were classified into the highest severity patient

groups compared with community hospitals.

There was a lot of disagreement about transfers. Community hospitals complained about two types of transfers: cases that were stabilized and then transferred to the specialty hospital where physicians had an ownership share for the procedure or surgery. And the second type were cases where the course of care didn't go well and the case was transferred to a community hospital. Data from one community hospital showed that one-third of its transfers from specialty hospitals died.

Specialty hospitals uniformly denied selecting cases based on payer mix but the specialty hospitals we visited had much lower Medicaid shares and provided less uncompensated care. One physician told us the specialty hospital had used the lack of uninsured patients as a marketing pitch to him.

Some selection may be a function of the referral base of the physicians. The specialty hospital may take all comers, but their referring physicians don't.

Service mix may be another explanation. For example, hospitals that don't have obstetric services or an ER will have a different mix of payers.

Turning to the impact of specialty hospitals on community hospitals, many site visit community hospitals reported large initial declines in volume associated with specific physicians who had moved their practices to specialty hospitals but that overall volume declined only slightly and mostly had recovered.

Surgical and orthopedic specialty hospitals had much more varying impacts, depending on the size of the community and the number of other hospitals in it. The replacement volume was reported to be less profitable. Most of the hospitals remained profitable.

In rural markets, volume declines were much more difficult for the community hospitals to rebuild. It was harder for them to recruit physicians and it was unclear if the community hospitals would fully recovered.

But community hospitals told us that rebuilding their volume was costly. The costs associated with physicians included signing bonuses, income guarantees and on-call pay, particularly we heard about for neurosurgeons and less frequently orthopedists. The costs associated with staff included retention bonuses for key staff members and offering raises to staff working the less desirable shifts.

All hospitals we spoke with talked about the hiring away of experienced staff, most often nurses but also pharmacists, radiation technologists and nurse anesthetists who were attracted by the better hours. Replacement nurses at community hospitals were typically recent graduates with much less experience.

Some community hospitals also added new operating rooms or new cath labs as inducements for their physicians.

Some community hospital administrators told us that the development of a community hospital in their market was like getting a wake-up call to make improvements. The community hospitals we visited responded to the pressure of specialty hospitals by improving their own performance. We heard numerous examples that included extending service hours of the operating room, improving the operating room scheduling and turnaround

times, and upgrading their equipment. But community hospitals told us there were limits to the improvements they could make in their efficiency given the wider range and more complex mix of patients that they treat.

Some community hospitals talked about the impact of specialty hospitals on the market's health care resources. For example, in Wichita, specialty hospitals had added 13 operating rooms and 130 beds. In Austin specialty hospitals had added 13 operating rooms and 89 inpatient beds. It was unclear if the added capacity is meeting unmet need or resulting in induced demand.

Some community hospital physicians raised concerns that physician investors were making medical decisions based on economic considerations, treating marginal cases where indications were less clear and perhaps performing surgery instead of pursuing a medical alternative.

Hospital relations with private payers varied widely across the markets we visited. Some specialty hospitals had been excluded from some private payer plans but this was unusual. Lower cost at some specialty hospitals had resulted in lower private plan payment rates. One payer noted that even though some of its per-service payments were lower, its total hospital spending could be increasing due to higher utilization.

We did not hear consistent differences between the quality of care provided at community and specialty hospitals. Some thought that because the same physicians practiced at both types of hospitals, often using the same protocols, that the technical quality would be similar. Some physicians practicing at specialty hospital thought the quality was higher at specialty hospitals where the nursing ratios were higher. Lower complication, infection and mortality rates at some specialty hospitals could reflect measured and unmeasured differences in the mix of patients they treat.

Physicians at community hospitals told us that the lack of diversity in a medical specialties practicing at specialty hospitals would weaken their peer review.

We heard about three types of retaliatory activities community hospitals had engaged in. One community hospital had adopted economic credentialing barring its physicians from investing in specialty hospitals and others were considering it. One hospital had included non-compete clauses in its contracts with its physician employees. One community hospital had removed all investor physicians from its ER rotation for unassigned cases, thereby taking away volume from them.

In conclusion, though there were distinct differences across specialty hospitals, there were common themes. Specialty hospitals appear to increase physician productivity and present revenue opportunities for physicians. They represent an attractive alternative for patients and their families. And they often stimulated community hospitals to make changes that would make their operations more efficient.

But there were concerns raised. First, there was evidence of patient selection, both in terms of the complexity and the payer mix of the patients treated at specialty hospitals. Some of the transfers raised concerns about the quality of care

provided by some specialty hospitals.

And finally, it was unclear if the expansion of capacity would increase service provision and, if it did, whether this would represent meeting unmet need or inducing demand.

MR. HACKBARTH: Thank you. Very well done.

This is the first of a series of presentations that we will receive on this issue over the next couple of months. I thought it would be helpful for the Commissioners just for Mark to outline what's to come so you understand where we're going from here.

DR. MILLER: I may miss a couple, but we've been asked to think about the payment system issues. And so we are doing work and will be bringing work to you on trying to look at the profitability of DRGs.

A way to think about this is many of the same issues that were just implicated in the site visit we're going to be trying to look empirically. So the profitability of DRGs, the selection issues between specialty hospitals and community hospitals, and whether more lesser severe patients. Trying to quantify more precisely the impacts on community hospitals.

Also, ideally we would look at differences in the quality of care but I want to be very tentative on that because our ability to do that with these small ends is going to be relatively limited.

Did I miss any of the big ones?

DR. STENSLAND: Cost differences.

DR. MILLER: Right. I lumped that into the community hospital impacts and looking across the two different facilities, relative cost, that type of thing.

DR. STENSLAND: And utilization.

MS. DePARLE: Did you guys look at anything about readmission from specialty hospitals to community hospitals? Are there impacts that you would expect to see there?

MS. CARTER: We did not look at that but if it's an area, if we were to do quality analysis, that would be one of the things we would look at.

DR. NELSON: A question, I presume that they are all Joint Commission accredited. Either that or else state certified, HCFA or CMS. That might be one area where some quality data might be obtained, from the Joint Commission.

I presume that you are, in terms of volume and utilization, are you looking at the small area variations and correlating the presence or absence of specialty hospitals with the volume of services within those areas?

DR. STENSLAND: We're planning to look at larger areas actually. One of the things we might look at is referral regions for cardiac care and look at utilization before the introduction of the heart hospitals and then after the introduction of the heart hospitals, to look at that rate of change in utilization. And if that rate of change differs from other referral regions that didn't have the introduction of heart hospitals.

DR. WAKEFIELD: Your definition of rural hospitals, are you using MSA/non-MSA? And I assume these are all PPS? Even though the bed sizes are small, they're all PPS? We don't have any CAH hospitals in this mix, do we? They're all PPS hospitals?

MS. CARTER: That's right.

DR. WAKEFIELD: Your comment about rural community hospital volumes, the sense that they're more difficult and having greater difficulty than their urban counterparts to rebuild volume, just a question thinking about a little bit of the threat potentially to the financial bottom line of some of the small smaller rural community hospitals and how that might over time affect access to services.

I know we're talking about a really small end when we're looking at the subcategory rural specialty hospitals, but can you tell me whether or not those rural specialty hospitals that you're looking at generally tend to have emergency rooms or don't? Do you know? The ones you looked at, the rural category?

MS. CARTER: They tend not to, the specialty hospitals.

DR. WAKEFIELD: Specialty hospitals in rural community tend not to?

MS. CARTER: Right.

DR. STENSLAND: In terms of ERs, almost all the staff ERs were at heart hospitals and I think there was only one in our sample of a non-heart hospital that had a fully staffed ER, where they would staff it with a physician 24 hours a day. And heart hospitals are usually in bigger markets because that's specialized. I mean, you can't have a heart hospital in a real small town.

DR. CROSSON: As I've thought about this, it seems to me that we have at least two compelling issues to look at. One of them is the impact of specialty hospitals, whether they're physician-owned or not, on the community hospitals. I think the issue there is that more or less community hospitals are viewed as a public resource, at least in some communities. And with respect to the needs of beneficiaries, damaging those would create a problem of access and potentially a problem of quality. I guess we're going to get into that issue later.

I think the second issue has to do with the potential for conflict of interest for owning and referring physicians, so I'd like to spend a second on that. It struck me that in reading the material that the advent of physician-owned specialty hospitals, particularly ones that are good deal smaller than community hospitals, seems to violate the idea of the whole hospital exception in the sense that -- you know, I wasn't there at the time. But my sense of that is that the whole hospital exception was placed there because it has something that might be called a principal of dilution.

That is that because the whole hospital takes care of lots of different kinds of patients and there's all different kinds of physicians admitting patients there that the likelihood that any one individual physician in a large general hospital is going to significantly gain by referral patterns and the impact of those on the profitability or lack thereof of the hospital is fairly small.

But that seems to have changed, at least based on the analysis that we had, where we have hospitals that have a census of 10, 20 or 30 patients and physicians who own up to 15 percent of the hospital. It seems like a different set of questions.

So when you think it through and say well, what might be a solution to this if that's the direction we're going in, one might be to try to return to some sort of balance that corresponds to the thinking of the whole hospital exception. At least as I think that through, it suggests something like limiting degree of ownership or potential profit that any individual physician could receive from ownership of one of these hospitals.

I would be interested in, as we get into this further, is to see if we could rough that out. And that would be what percentage of ownership of the average physician specialty hospital, based on what we know about the profitability of those hospitals, would have what impact on the annual income of the average physician? I realize that there's a lot of modifiers there.

And yet, this is not an unknown dilemma in medicine, which is how to balance the impact of finances on the professional judgment of physicians and other professionals. I think it's a human fact that judgment is more likely to be influenced by the potential to gain $1 million than it is by the potential to gain $5,000, at least for someone who's already making a substantial amount of money.

And I just would offer that we might take a look at that.

MR. HACKBARTH: Let me just pick up on your initial framing of the issue. I think of it coming in three basic parts. One is their effectiveness on professional judgment of physicians.

A second, as you said, is the impact on community hospitals and their ability to provide services to the public that may not be completely funded, adequately funded through other means, means other than cross-subsidies.

And then the third that I would include is the accuracy of payment. Is the way that we're paying for patients creating opportunities for selection of certain types of patients and then exceptionally large profits on those patients?

Those are the three big issue categories that I see here.

DR. MILSTEIN: I think that our being able to make a strong recommendation in this area is going to very much hinge on the quality of the underlying analysis. And I'm also respectful of the fact that we have limited time to complete that analysis. So my comments are really directed at some of my thoughts on what the analysis might, at a minimum, want to include if we're going to have maximum confidence in our recommendation.

I think of there being three major categories of potential impact of this new life form, one being impact on appropriateness. We have bases in this country for judging appropriateness. It's not particularly sensitive but the American Heart Association and American College of Cardiology have given us a three-part classification system. I don't know how feasible it's going to be to see if we can piggyback on research already underway or otherwise be able to get a sense of what the distribution is in specialty hospitals serving heart patients versus community hospitals on the distribution of cases across the three AHA ACC categories.

The second area of potential performance impact would be cost efficiency. That is, assuming that the treatment made sense

to begin with, are these specialty hospitals more cost efficient, either using charges per stay or charges per stay -- as Nancy was inferring -- to some kind of downstream longitudinal notion analogous to what Jack Wennberg has shown light on.

To the degree possible, it would be great if our cost efficiency analysis, irrespective of what longitudinal time frame we use to denominate it, could do everything we can to ensure that it includes a trued up analysis for cost of teaching, research -- obviously both efficiently provided as we previously discussed -- indigent and underinsured care, truing up for that difference. And also for what we believe to be the cost of the standby capacity associated with having to accept transfers in when patients don't do well and need to be handled by community hospitals.

And then last is this question of patient outcome. Are we pursuing opportunities to partner with the American College of Cardiology or the Society for Thoracic Surgeons, both of which maintain the only really good quality risk adjusted outcomes database, at least for heart care.

I know that at least some of the specialty hospitals that I've interacted with do participate in those programs and they do the best that science can now do for us in terms of a good risk adjusted comparison of outcomes for two of the primary procedures being done at least in heart hospitals, being bypass graft and various PCI procedures.

So we have limited time, limited budget, but I think our confidence we would have in our recommendation will very much hinge on the quality of our analysis.

MR. MULLER: Let me also commend the three of you and the rest behind you who did all this work. I think it's very well done and I look forward to the work that Mark indicated is to come.

Some of my comments really have been anticipated by what Jay and Glenn and Arnie had said.

But I think the thesis as to why is it in heart? Why is it orthopedics needs to be tested a little bit more. Why don't we have a lot of birthing hospitals? Why don't we have neurosurgical hospitals? One can surmise that perhaps in neurosurgical cases there just aren't enough to create a hospital.

Why don't we have breast cancer or prostate cancer hospitals? My sense is some of it has to do with volume and some of it has to do with the thesis of where the payment system may be skewed and therefore we should look at that.

But if you look at societal need, if you did it on the basis of need, one might think that there are other kinds of specialty hospitals that come forth if we look at societal need and they may be more linked to payment system than it is to need.

So I think we need to look at some other specialty areas and see whether there's something in the payment system and so forth that doesn't cause them to come forth.

I'm not going to repeat the necessity of getting the outcome and margin data, which I think is very important in this, so I look forward to that coming forth.

I do think we have to, and we've discussed at other times in

other settings how well the DRG recalibration goes on some kind of basis. But since at least the number of these hospitals, more from what your analysis indicates on the orthopedic side than on the heart side, have a lot of private payers where the charge system -- which we'll be talking about later -- may have some effect on the margins.

My sense is that if the charges are higher in certain areas within a year or two, the DRGs should be recalibrated to take that into account. But there seems to be something going on that over the years -- I mean heart hospitals and heart services with general hospitals have been more profitable than other services for probably 10 years or 20 years, since 1983 and so forth.

So there's something going on here where recalibration doesn't work quite as well. I'm not quite sure what it is and whether, Glenn and Mark, you want to do that inside this study or elsewhere. I think it's something we have to keep looking at because there does seem to be consistency over a period of years in certain services being more profitable and other services being less so, even inside the Medicare system let alone inside the private payment system.

So to sum it up, I think Jay's points about looking at the effects on the community is something we should look at. Certainly if there's any way of trying to capture those standby costs that general hospitals or community hospitals have to sustain that are not captured in hospitals that don't have ERs – I mean, you don't want to judge off anecdotes but certainly if you have to turn the lights on in an ER, then the marginal costs of running that ER have to be pretty low.

Therefore, the staffing may not -- my guess is there weren't staff standing there in the dark. So they probably didn't have a lot of staffing costs in that ER.

So I think looking at those kind, whether there's some kind of way of capturing what the general standby costs are of these community hospitals vis-à-vis the specialty hospitals. The drive toward specialization, not just in specialty hospitals but one can see it in imaging centers and labs, et cetera, and so forth, is not going away. And given that is by and large where our economy develops, there's no reason to think that even if there's some changes along the lines that may or may not come out of Jay's comments in terms of what kind of limitations we put on these, the drive towards specialization is going to continue.

So thinking about what the advantages are of specialization vis-à-vis the general role of community or facilities and what they can do in general for the needs of the public that Medicare serves, I think is an important thing for us to keep looking at because, in fact -- once you undermine that general capacity it takes an awful long time to bring it back.

So the whole sense of what we get out of specialization versus the costs of it, whether this is the right time to take that on. But I think that's a theme we have to keep going on, not just in specialty hospitals. Because at this moment we don't have whole imaging hospitals. They still tend to be imaging centers. But based on the work we did a year two ago, we know that's one of the biggest proliferating areas within Medicare. I think we had growth rates about 14 or 15 percent in imaging. So

one could conceive that three or four or five years down the road that we have whole imaging hospitals. There's reasons to think they're not 12 months away but one could see this happening, as well.

So again, looking at the community hospital costs, vis-à-vis the specialty hospital costs, looking at the margin outcome data, looking at, looking at the DRG recalibration system I think is very important to see why after 20 years we still have some services continuing to be making more margin.

And then any thinking we have about why there's some services that are very much needed by communities. Around the country right now, due to malpractice crises and other issues, the availability of OB services is being restricted. If there's a community for OB services, why don't we have birthing hospitals being created to meet that need?

MR. SMITH: Much of what I wanted to say has been said by Ralph and Arnie and Jay. So let me just try to dig in on a couple of those points.

Glenn, I thought your three-part distinction was right, the professional judgment/community impact/payment accuracy. I want to pick up on something Jay said, sort of linking the question of how this economic arrangement works out to the question of community impact. It's important to understand that the impact on community hospitals is going to be the same whether or not the competing local heart hospital is investor-owned or physician-owned or some mix. And I suspect that the normal financial transaction here is investor initiated and who recruit physicians rather than, as was adjusted in the slides, the other way around.

So as we look at community impacts, I want to make sure that we look at the impact of specialty hospitals, the kinds of broad specialization questions that Ralph was raising, not simply the impact on community hospitals, the ones where physicians are part of the ownership mix. And concentrate on the physician side on the impacts on professional judgment.

The standby capacity. we should remember, there are two pieces of this. In the report from the site visits, Carol told us both that community hospitals had become more efficient, had invested more and had improved their general performance, and that they had also shut down some services. We need to think about how those things interact.

And it's partly a function of just reduced income because payment is flowing to new competitors. But it's also the question of whether or not you can then any longer afford to maintain a services or to keep it open. The community impact question is a complicated one.

And lastly Jay, I'd be a little concerned about thinking we can capture how much is corrupting and decide that the dividing line is 15 percent or 13 percent and that at 16 percent you're hopelessly underwater, for a couple of reasons. One, because I think it's very hard to do that. But second, because these financial arrangements are very complicated.

I could have as big a financial stake in my referral pattern because I owned a real estate investment trust that invested in a lot of hospital real estate without ever having an equity stake

in the actual operating hospital.

So I think it's awfully hard to say this much, both as a matter of sort of ethical analysis, but also the financial transactions I think bedevil this in ways that we ought to be careful not to think that we know more than we do.

MR. DeBUSK: As you know, the hospitals right now are going through a real increase in the number of uninsured patients that's showing up at the doors. And going forward, I think if we can get at some more recent data about the uninsured, that would be very important to look at in this report.

MR. BERTKO: I'd just liked to add a thought about one of Arnie's comments. Sometimes getting to quality and outcomes data can be very difficult. I'll point to, I think, the transfer comment on slide 30 to say maybe some of your analysis on the costs might be patient-based as opposed to admission or episode based. If you could link them together, that is if a patient starts in one facility and transfers to another, what's the overall average cost in say some of the site visits? I would hope that that might be a more practical approach in some cases.

MS. RAPHAEL: I was very interested in the concentration of specialty hospitals in four states, I think it is. I was wondering if we could learn more about what's happening in the states?

For example, can you tell us what led to Florida prohibiting specialty hospitals? And are there any studies that have been done at the state levels that have kind of informed some of the decisions whether to allow for licensing or to prohibit it?

MS. CARTER: I would have to get back to you on those. I know that a number of hospital associations are conducting their own studies of specialty hospitals, so I can look into that for you.

MR. DURENBERGER: First, I'd like to start, too, by complimenting the staff and not just for the presentation that's in front of us now, but the work at the retreat where everything was a little bit more relaxed and getting your consultant in. That was really, really helpful, Mark, in the way in which we were able to prepare for the subject, for me and I think for everybody else, laying the groundwork for this was really great.

Secondly, I want to acknowledge that every once in a while somebody leaves the policymaking arena who makes a significant contribution by doing something with looks negative, and that's John Breaux. I think about all the people that are going to be missed around that place, as the number of good folks dwindles. John is probably -- for those of us who had experience with him -- going to be missed the most.

He's the guy that contributed the moratorium, which I don't think he necessarily believes is the ultimate solution to the problem. But he made everybody stop in their tracks and say this is really an important issue.

And I want to endorse the comments of all of my colleagues about not just looking at this as fulfilling a mandate or something like that. But I think as you pointed out, Mr. Chairman, this covers a lot of the other work we're doing. And so I want to endorse your three categories. I think that's the best way to say it.

In the issue of conflicts of interest and physician judgment one of the most important judgments -- that's why I like Arnie's suggestion to work with ATS, working with AAOS, those kinds of people -- the connection between physician judgment, ownership and productivity is really very important. And how we define it, whether you define it as a Permanente, you define it as a Mayo, a Cleveland, whatever it is, there's something very, very important to all of us in terms of enhancing the quality of the work, the quality outcome, in having some kind of an interest, if you while, measured financially, measured profession and so forth, in that outcome.

So however we look at this so-called -- conflict of interest sounds like a negative connotation. It would be nice to flip it over and say there's a positive side to this, as well. And then, as we deal with the positive side of it, how do we guard against conflict of interest or something like that?

But there's a whole lot of issues that my colleagues have commented on that belong in there. But the importance of the connection between ownership and productivity, I think, is really critically important.

And then the other two that we've already commented on, that I simply want to endorse because of their importance, the whole issue of the pricing distortions. We already know, from our work, that we're overpaying hospital outpatient compared with ambulatory surgery centers. We'd love to know why. A lot of other people would love to know why.

But we're already doing that kind of work. So it seems like some of that work is incorporated in here. I haven't read Joe's book yet, but I'm looking forward to reading Joe Newhouse's book on this whole issue of price distortion because I think we're not going to solve it in this study but I think it's really critically important to look at that in the light of the other things we're doing. And that includes the efficiency analysis and stuff like that.

And the third one that's really hard to deal with but it needs to be referred to is the issue of cross-subsidies because that's the one that distinguishes one community from the other and it gets really very difficult, from a public policy standpoint, to deal with it.

And yet, if we're thinking about beneficiaries and we're thinking about high-quality care and we're thinking about how to get the best that medicine has to offer to everybody in every community, we do need to deal with that issue of cross-subsidies, as you pointed out. And in some way at least point policymakers to the failures in the current system that deal more appropriately with issues like uncompensated care and Medicaid payments and a variety of things like that.

So I basically just want to endorse the comments of my colleagues and the work of the staff so far.

MR. HACKBARTH: Just to pick up on your first point, it's difficult not to feel ambivalent about some of these issues. On the one hand, people are understandably concerned about compromising professional judgment through inappropriate financial incentives. But in many instances over the years, we've talked about the need or the potential for aligning the

incentives of physicians and hospitals to do good things for patients and improve the efficiency of the system.

So there is little that's black or white. The trick here is to find an appropriate blend and it's a very interesting problem, as well as a difficult one.

DR. WOLTER: Just an observation and pick up a little bit on something that Jay said earlier. I think one of the things that is happening is there is this blurring on between ASC, specialty hospital, and whole hospital. And as ASCs add overnight capacity, as ancillaries of one kind or another are added, specialty hospitals are of one size or another. Some do several service lines. Some are primarily one service line. And that really complicates, I think, this issue.

Which is why I think the core issue around self-referral and what Stark covers and what it doesn't cover really is one of the key things that we need to address.

I like Dave's suggestion that maybe there's a way to flip this and look at it positively. For example, in the Stark regulations there are the group practice exceptions where physician ownership is certainly allowed of some of these services but there are distinctions about how salaries are created directly related to the referral to certain service lines versus sort of how the organization as a whole performs.

So I think there are some distinctions that we may be able to get into that would help us as we move forward.

DR. SCANLON: I'd just like to make a short comment. I think that the prior comments have really revealed some of the complexity of what we're dealing with here. And I think, given our time frame, the ability to deal with many of them is going to be constrained.

Unfortunately, I want to add another issue to the table which is that the idea that we are talking about hospitals may be a misnomer in terms of how we characterize this issue because our hospital, in some respects, is a building concept. It's what goes on in a particular building. The entities that we're talking about may be something that's owned by a system, owned by a chain. And I think that totally changes the economics that is underlying the issue here.

If a community hospital chooses to do its cardiac surgery in another building that is independently certified, that's completely different than if an independent entity opens up and takes patients from that community hospital.

If we think about we're going to change rules with respect to referrals under Stark, how are we going to think about all of the permutations that may exist in terms of the kinds of arrangements that might exist?

Jay's idea of a threshold in terms of ownership, that may be an interesting avenue to pursue. But then again, when we're talking about a chain, how the threshold rules would be adapted to deal with that issue.

Given all of this, I think I comeback, Glenn, to your characterization and think that you really have hit on the three big areas. And at a minimum we maybe should be very intent in focusing on the question of the payment system and what is the payment system doing here? Is it, as Ralph indicated, failing in

terms of the recalibration effort? And that we need to be worried about what the consequences of that failure are in terms of creating incentives for the system to operate in one way or another.

I think that may be, at a first step, the most important piece of what we do.

MR. SMITH: Glenn, I was struck several times during this discussion but particularly at Dave's last comment about how seamlessly we have made a transition from a conversation we've often had about impact on Medicare beneficiaries to impact on the entire health care system at a community level. We've asked ourselves, and we are entering in this one in a significant way, to what extent should we think about Medicare's role in the health care system or simply Medicare's ability to provide high-quality services to its beneficiaries?

We haven't in this discussion, not a single one of us has confined ourselves to beneficiary or access issues. we've talked about much broader impacts. I think that's a step forward but it struck me as an important transition.

DR. CROSSON: Just a couple of last comments on the physician incentive issue, and I do agree with Dave that probably characterizing it as incentives or the appropriate balance of incentives is a better way to put it. Because that's really what it's about. It's really about trying to get incentives or trying to influence incentives in such a way that they're balanced, balanced between quality, professional judgment and the finances, the complex finances.

It is messy. There's no question about it. You're mixing up law, finance and human motivation. If we can only get rid of that last part it would be a lot easier, because once you get that in it is messy.

And I would say again that while that's true, yet other laws that we have heard summarized earlier have attempted to do that. So that as the Stark laws were put into place, people tried to wrestle with these issues and accepted some things and allowed other things. For example, the whole hospital exception. I believe that was done because folks looked at the likelihood of extraordinary incentives and decided that they were not present and therefore that should be allowed.

So even though that is messy I think nevertheless, to be responsible, those kinds of judgments need to be made when they can and when they're appropriate.

The last note is, having said all that, I think we did get a case presented by the staff that there were other reasons why physicians involve themselves in creating these hospitals, some of which were subsequently addressed by the community hospitals, others of which were not.

I would just say that while the incentive issue is a real one, there's a separate issue of physician governance. And as we work our way through this I think we should, if we can, consider those things differently because there may be a compelling reason in these hospitals to have physicians involved in governance in a major way. And yet, there may be reasons to separate that from ownership, if that's possible.

DR. REISCHAUER: Just a footnote on that point, and that is

to go back to Ralph's question which has why haven't these specialty hospitals sprung up in other specialties? Because certainly it isn't only the cardiologists that are upset with the management of the community hospital. And so I think we get, as you said, right back to the getting the payments right issue first. And then see what the ramifications of that are.

Just one comment on the community repercussions and how complex this is really going to be for us. Everybody is concerned that proliferation of specialty hospitals could reduce the social benefits that come from having a community facility. But the question we et into immediately is how much do you need of that?

We're often talking about communities with three full-service hospitals and the fact that one of them is having a huge problem because the heart and orthopedic business went somewhere else can be true for that hospital, but in a sense may not be true for the community as a whole because we don't know what that threshold level is of this social benefit that we want to preserve. And we want to preserve it for the community but also for the Medicare beneficiaries in everything else that they might do.

MR. HACKBARTH: I was struck also, Dave, by that seamless transition. And I think a complete analysis of this issue requires careful consideration of the community impact of this development.

On the other hand, there are huge issues in terms of how you finance those desirable public goods. At one extreme you finance them through cross-subsidization. You basically protect from competition. You allow the payment system to be inaccurate and people to reap large profits here to cross-subsidize social goods there.

The other end of the continuum is that you promote competition, especially competition that is quality enhancing and efficiency improving and then say if we want those public goods we pay for them directly.

I think one of the intriguing aspects of this issue is that it forces that discussion out into the center stage.

DR. NELSON: I think we have to recognize also, though, that the development of heart and orthopedic surgical techniques has come a long way in the past 10 years. There are people walking around with their knees done that we wouldn't have thought of that 10 years ago.

By the same token, the advancement in cardiovascular surgery, because of new technology and transfer of that technology, there is obviously an increased need for facilities to handle that.

You can't say the same thing about gastrectomy because that's gone the other way. And endoscopic surgery has changed the face of a lot of abdominal surgery.

So I have no doubt that payment policy is a factor but it's certainly not the only factor.

MR. HACKBARTH: Any other comments or questions?

Okay, thank you very much. Good piece of work.